

POLICY: MANAGEMENT OF PRESCRIBING WITH EMPHASIS ON ADDICTIVE OR DEPENDENCE-PRODUCING DRUGS

It is not what you prescribe, but how well you manage the patient's care, and document that care in legible form, that is important.

The prescribing matters that come before the Board are almost always related to the prescription of controlled substances. We feel that a majority of instances where physicians have been disciplined by the Board for prescribing practices could have been avoided completely if they had followed the steps that are being outlined here.

To prevent any misunderstanding, it is necessary to state what the Board **does not** have.

It **does not** have a list of "bad" or "disallowed" drugs, except in certain circumstances, amphetamines, amphetamine-like substances and central nervous system stimulants. (See, Board of Medical Examiner Rule 0880-2-.14, a copy of which is available to you by contacting the Board's administrative office at (615) 367-6231.) All formulary drugs, except as previously noted, are good if prescribed and administered when properly indicated. Conversely, all drugs are ineffective, dangerous, or even lethal when used inappropriately.

It **does not** have a some magic formula for determining the dosage and duration of administration for any drug. These are aspects of prescribing that must be determined within the confines of the individual clinical case, and continued under proper monitoring. What is good for one patient may be insufficient or fatal for another.

What the Board **does** have is the expectation that physicians will create a record that shows:

- Proper indication for the use of drug or other therapy;
- Monitoring of the patient where necessary;
- The patient's response to therapy based on follow-up visits; and
- All rationale for continuing or modifying the therapy.

STEP ONE

STEP ONE First and foremost, before you prescribe anything, start with a diagnosis which is supported by history and physical findings, and by the results of any appropriate tests. Too many times a doctor is asked why he or she prescribed a particular drug, and the response is, "Because the patient has arthritis." Then the doctor is asked "How did you determine that?", and the answer is, "Because that's what the patient complained of." Nothing in the record or in the doctor's recollection supports the diagnosis except the patient's assertion. **Do a workup sufficient to support a diagnosis** including all necessary tests.

STEP TWO

Create a treatment plan which includes the use of appropriate non-addictive modalities, and make referrals to appropriate specialists, such as neurologists, orthopedists, psychiatrists, etc. The result of the referral should be included in the patient's chart.

STEP THREE

STEP THREE Before beginning a regimen of controlled drugs, make a determination through trial or through a documented history that **non-addictive modalities are not appropriate or they do not work**. A finding of intolerance or allergy to NSAIDs is one thing, but the assertion of the patient that, "Gosh, Doc, nothing seems to work like that Percodan stuff!" is quite another. Too many of the doctors the Board has seen have started a treatment program with powerful controlled substances without ever considering other forms of treatment.

STEP FOUR

Make sure you are not dealing with a drug-seeking patient. If you know the patient, review the prescription records in the patient's chart and discuss the patient's chemical history before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum obtain an oral drug history, and discuss chemical use and family chemical history with the patient.

STEP FIVE

It is a good idea to obtain the informed consent of the patient before using a drug that has the potential to cause dependency problems. **Take the time to explain the relative risks and benefits of the drug and record in the chart the fact that this was done.** When embarking on what appears to be the long term use of a potentially addictive substance, it may be wise to hold a family conference and explain the relative risks of dependency or addiction and what that may mean to the patient and to the patient's family. Refusal of the patient to permit a family conference may be significant information.

STEP SIX

Maintain regular monitoring of the patient, including frequent physical monitoring. If the regimen is for a prolonged drug use, it is very important to monitor the patient for the root condition which necessitates the drug **and** for the side effects of the drug itself. This is true no matter what type of controlled substance is used or what schedule it belongs to. Also, remember that with certain conditions, drug holidays are appropriate. This allows you to check to see whether the original symptoms recur when the drug is not given - indicating a continuing legitimate need for the drug or whether withdrawal symptoms occur - indicating drug dependence.

STEP SEVEN

Make sure YOU are in control of the supply of the drug. To do this, at a minimum you must keep detailed records of the type, dose, and amount of the drug prescribed. You must also monitor, record and personally control all refills. Do not authorize your office personnel to refill prescriptions without consulting you. **One good way to accomplish this is to require the patient to return to obtain refill authorization, at least part of the time.**

Records of the cumulative dosage and average daily dosage are especially valuable. A thumbnail sketch of three hypothetical cases will illustrate our point here. In the first case, a physician prescribes Tussionex to a patient for approximately five years for a cumulative dosage of nineteen and one half gallons. In the second case, a physician prescribes, Tylenol 3's to a patient for slightly more than a year at the average daily rate of 30 per day! The third case is very similar, except that it was Tylenol 4's at the rate of 20 per day. Some quick observations:

- No physician who was aware of that kind of prescribing would have continued with it.
 - Few, if any, patients could have been consuming that much Tylenol with codeine. In all likelihood, they were reselling it.
- Another important part of controlling the supply of drugs is to check on whether the patient is obtaining drugs from other physicians. Checking with pharmacies and pharmacy chains and other health care providers may tell you whether a patient is obtaining extra drugs or the patient is doctor shopping. If you are aware it is occurring, contact other physicians and health professionals in your area.

STEP EIGHT

Maintaining regular contact with the patient's family is a valuable source of information on the patient's response to the therapy regimen, and may be much more accurate and objective than feedback from the patient alone. The family is a much better source of information on behavioral changes, especially dysfunctional behavior, than is the patient. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug

is withdrawn. These changes, at either time, may be a symptom of dependency or addiction.

The family is also a good source of information on whether the patient is obtaining drugs from other sources, or is self-medicating with other drugs or alcohol.

STEP NINE

To reiterate, one of the most frequent problems faced by a physician when he or she comes before the Board or other outside review bodies is **inadequate records**. It is entirely possible that the doctor did everything correctly in managing a case, but without records which reflect all the steps that went into the process, the job of demonstrating it to any outside reviewer becomes many times more difficult. Luckily, this is a problem which is

solvable.

Adopted by the Board of Medical Examiners on this the 19th day of September, 1995.

**Oscar M. McCallum, M.D., President
Tennessee Board of Medical Examiners**

Note

The above policy was taken almost verbatim from the practice statement issued by the Board of Medical Examiners of the State of North Carolina in February of 1991 to all its licensees. We express our appreciation to them, and the Minnesota Board of Medical Examiners who originally distributed this information in 1990, and acknowledge the authorship by those two Boards of this nine step process.